AZ Medicaid Outpatient Workgroup Meeting

April 21, 2004
4:00 PM to 4:30 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Sara Harper, AHCCCS

Attendees:

(Based on sign-in sheets)

AHCCCS	**DES/DDD**
Barbara Butler	***Marcella Gonzalez***
Melonie Carnegie	***Major Williams***
Rebecca Fields	**Health Choice**
Cia Fruitman	***Lori Owens***
John Murray	***Kathy Thurman***
Lori Petre	***Rob Tibbs***
Brent Ratterree	***Mike Uchrin***
Mark Renkel	**IHS**
Mike Upchurch	***Charolett Melcher***
Diane Sanders	**MCP/Schaller Anderson**
Kyra Westlake	***Anne Romer***
APIPA	**UFC**
Sharon Zamora	***Kathy Steiner***

1. Welcome (Sara Harper)

Hi, I am Sara Harper, and this is the first official meeting of the Consortium Technical Workgroup regarding system implementation issues for the Outpatient Hospital Fee Schedule that is to go up 1/1/05. I am going to talk about a few other issues first before we go on with Outpatient. I have been meaning to update you on what is going on with some rate changes. I am going to give a follow-up on the things that we have been talking about in the last few meetings.

Rate Schedule

Fee-for-service hospice rates are being retroactively adjusted for 10/1/03. The email notice is going out today to all contractors. It was discussed at the CEO meeting last week; it will be discussed at the program contractor meeting this week. It will be in Claims Clues and Encounter Keys and our typical standard notification. I believe that the notice is also on the web. There was a Federal requirement that we became aware of in November that adjusts the 10/1/03 rates slightly. If contractors have contracted with the hospice providers for other rates, this does not affect you. However, if you are using our fee-for-service rates, then this will affect you. It is not that much, but it was enough that CMS said AHCCCS needs to get in line for 10/10/03, so we had to make a retroactive adjustment which we are doing.

Fee Schedule

The Fee Schedule update that was originally scheduled for 4/1/04, which got delayed to 5/1/04, is on for that date. The file will be on the FTP server; I am told if all works as planned, the afternoon of 4/30/04. It won't be available on the website until the first week of May sometime because the website is closed for us to make adjustments as they are making changes to the AHCCCS website. We have to wait until that process is complete before we can publish any changes. An update memo did go out to all the CEO's and Program Contractor Administrators just the other day. It was discussed at the CEO meeting last week, and it will be discussed at the program contractor meeting this week. If you have any specific questions on that, please let me know. My staff can get you most any information you need to know. It won't be in the format that you get on the FTP server, but we can certainly answer questions that you have relating to that Fee Schedule Update, which includes two pieces. One is the Medicare rate adjustment with the exceptions with some services areas that we normally don't use Medicare rates for such as maternity, transportation, anesthesia and dental. The other item that we are doing is the facility/non-facility rate adjustment. We are implementing a new program for us. This is the facility/non-facility adjustment to certain types of procedure codes that have a differential based on where the service is provided. We delayed it for one month because we wanted to limit the affect on some providers, because there were certain providers that were heavily impacted by this adjustment than we felt comfortable with so we wanted to limit that impact. We are phasing it in. Eighty percent of the procedures are going to look just like Medicare's facility/non-facility adjustment, and about twenty percent were modified to limit the impact on providers.

Outpatient

The big thing that we are here for today is the first Consortium group for the technical system issue related to the implementation of the Fee Schedule for 1/1/05. CEO's have also requested that we have another workgroup that is more operational. They were all sent emails to make a choice of the best time for the Outpatient Operational Workgroup, Tuesday afternoon or Wednesday morning. So far the votes are 6 to 2; we have heard from only 8 so there are a few outstanding yet. It looks like it is going to be Tuesday, 4/27/04, from 2-4 p.m. I will know for sure by the end of today, and the first thing tomorrow morning, I will have an email out to everyone telling when that will be. That meeting next week will be more operational in nature. There is going to be a presentation by the consultants of the proposed Fee Schedule methodology. Everything the consultants have designed today that is in our proposed methodology gives you the background of how the whole Fee Schedule was derived, and it gives you the base for that.

We will also provide other documentation that we provided to the hospitals so that everyone has the same information to work with going forward. I am not sure whether at that meeting we will provide them with the draft requirements for the system; that has yet to be defined. If there are parties that are interested, we will certainly make that information available. We are going to keep two workgroups going. This workgroup is more the system, and we will always keep this group going. We will provide information to you on the Outpatient Fee Schedule in this forum. We will have the additional workgroup that is more the operational piece of it. I am not sure how often the Outpatient Operational Workgroup will meet, as we have not really had a chance to discuss it. There might be some overlap. Since we have this forum set up with the email communication, etc., we want to use this as the main core for the system issues since it has been established, and it seems to be quite successful in the way of communication with all systems people on issues. We are also looking to eventually hire consultants who will serve as a liaison between contractors and their systems issues, AHCCCS, and the hospitals to make sure that everybody's systems are working together towards this implementation. We are going to have testing, as you will see on the time schedule. We are going to have a consultant to help work with us on the testing to help coordinate those efforts. We will be providing more information as that consultant comes on board, and we have their responsibilities more defined. We want to make it so that everyone has open communication. I believe that we are going to establish an email address for the Outpatient Technical Workgroup.

Lori Petre – Yes, we will establish another email address and handle the issues and the tracking similar to what we do with the AHCCCS HIPAA Workgroup. I am hoping to have that finished by Friday. We will send that email address out to you once it has been established.

Action Item: Lori Petre
Send the Outpatient Technical Workgroup the related email address for issues.

I would like to keep this forum in conjunction with the Consortium meeting since all of you are already here at this location so it is convenient. It is a great avenue for us to have. From here, I will let Lori take it, she is going to do the initial walk through of the productive timelines, our system requirements for what we are doing, and then they have provided the ISD Requirements Worksheets for Provider, Reference, and Claims as well as our Encounters system. The handouts that you have are draft documents as we agreed to share these as soon as possible. This is very close to what it will look like when it is finalized.

Lori Petre – You should have the Outpatient Hospital Capped Fee Schedule Project Timeline document, which is primarily what we are going to talk about today. There are two ISD Requirements Worksheet draft documents, one for Provider, Reference, Claims, and one for Encounters. The reason why separated those subsystems out is because some of the actions that need to be taken are separate, and it is a little easier to follow those changes specific to Encounters within that document. We will review the timeline document, which is also in each of the requirements documents as part of our standard layout.

ISD did receive the requirements from Division of Health Care Management (DHCM), which is the division that Sara and Brent are both a part of, by the first 4/04. Mike Upchurch and his staff completed the two draft requirements documents. It is expected that we will have those finalized by 4/28/04. Usually approval takes a couple of days afterwards. Once we have finalized the system requirements, we send them over to Brent, Sara, and Cia, to give them an opportunity to review them to let us know if we missed anything. Once we finalize the requirements, we do start on our system proposal, which is our design. That draft we expect to have available by no later than 5/14/04. If we have an earlier draft, we will make sure we share that with this group. Probably what we will do is set up email groups like we have for HIPAA. We expect system design to be finalized by 5/14/04. We are going to nail down how we are going to handle this within our Provider and Reference subsystem, which are what support our Claims and Encounters processing, and in our Claims and Encounters systems. We are going to try to have these project workgroup meetings as either a pre-cursor to the Consortium meeting, or

immediately following it, which is somewhat dependant upon when we can get the room. Right now, we are targeting future meetings as being scheduled in conjunction with the Consortium meeting. The Consortium meetings are currently only scheduled through 6/23/04, but there will be subsequent scheduling. We will update as that happens. I am currently working on setting up a unique email address like the AHCCCS HIPAA Workgroup email address. There will be a workgroup email address for this group to send your questions, issues, etc. They will be handled much the same way as the HIPAA Workgroup. If it is a question that Sara should respond to, it will be assigned to her, etc. I do hope to have that done by Friday; once it is done, I will send out an email informing you of what email address is. Our system development will then start immediately following the finalization of design. That is projected to take several months as you can see by the schedule; is expected to conclude on 8/6/04. For the meetings that occur in the interim, we will be sharing with you our progress against design. We are going to walk through the design with you, and at an interval point before it goes into testing we are going to walk you through what we actually did. Sometimes when you get into design, you tweak it, find some surprises, etc.; we will be filling you in on those things as this goes along. We refer to those as construction walk through. Immediately following that system development, we will perform system/integration testing. That is the testing that is generally performed by my staff, the ISD Testing Team. We are going to be looking for hospitals that would like to test with us. We will also be looking for some health plans that would like to do the same thing. We will do pilot testing 10/04 with trading partner testing scheduled to take place 11/1/04 – 12/15/04.

Q: Is the User Acceptance Testing included in the 10/1/04 timeframe?
A: Yes, that is included in the trading partner testing.

Sara Harper – We are going to put up table structures earlier. If health plans want to implement effective 1/1/05, we will have the table structure to do so. We are proposing some session law that will make it so that while we are undergoing this change, your current payment methodology will remain the same until such time as you system test and are up. The agency will be offering incentive plans to be ready on 1/1/05. That is the definite direction that we are taking based upon conversation that executive management has had with health plans. We are very much pushing for the 1/1/05 implementation.

Lori Petre – The document attached to the Project Timeline is a flowchart that Cia Fruitman will discuss. I took Cia's handwritten flowchart, and put into a more standardized format. I think we were able to capture those things that you had in it as well as some of the notes regarding editing that we discussed internally.

Cia Fruitman – This is a primitive flowchart, but it is prettier than the first one I did! This will tell you how we are going to change processing claims as we go through the payment. Right now, on our side, the claims are not going through editing for the procedure code. We will be putting in the edit of field to be priced by the Outpatient methodology, which are your outpatient claims, the inpatient claims that are going to be painted outpatient because there is no cover accommodations, as well as the critical accident hospital bill types. Those will be the edit tables and other tables referenced in the document. We are going to start using modifiers, which we have not used in the past. The system will have to determine if it is a valid modifier, and if it is a valid modifier for that procedure code. There will be a new table, and it will look a lot like the RF113 – Procedure Code Indicators and Values table as we are going to clone it. It will be a new limit table. We need a new limit table, because the limits will be different for the hospitals than they are the 1500s. If it passes the edits, great! If it doesn't pass the edits on the encounter side, the encounter will have to pend. On the claims side, the lines that don't pass will be disallowed, and they will have to resubmit the lines that didn't pay. In general the hospital should be submitting procedure codes on the detail line level. We will then price it which will require us to create another new table that is going to tell us if the line is part of a bundled fee or is if it is going to be priced on a per procedure level. What is going to happen is for surgery and for emergency room services; the way we built and are going to pay the rate is as a bundled rate. All of the codes normally associated with an ER visit or with a surgery are bundled into the payment. This

is on a revenue code line level. The next step is if it says 'yes', it is a bundled rate, and then there is a table that gives all of the revenue codes at bundled rates so that you do not pay on a per line basis. For surgery supplies, drugs, etc., are bundled into the payment. The exception to Medicare type of bundling is that we are always going to be paying separately for labs and radiology; they were not bundled into the reimbursement, which is a real deviation from the Medicare concept of bundling. If it is a procedure that is bundled, and the details on that are a little sketchy because we have not yet determined them, but basically if it works, it could be your 45X revenue codes or it will be your 45X revenue codes linked to the procedure code. We have not quite formatted how this table will work. If it is bundled, it will go through and tag the lines that are bundled so you don't pay them separately. It will value the primary codes that are for the ER, for the surgery, and value the codes that are not bundled. If it is not bundled, it will go to the fee table. There will be a fee table that looks a lot like the RF112 – Procedure Maximum Allowable Charge table that is out there right now. You won't have the piece that we have just added, which is POS, because POS is always hospital. There will be a fee, and it will be code and amount driven with a begin and end date of service. It will work just like the one that is used for the Physician Fee Schedule so we are going to assign a rate. If there is not a rate on that table, we will have a default CCR. We are anticipating that will be roughly 5 percent of the codes that are out there who's revenue lines will not have a rate. This will apply to the revenue code lines that you don't need to have a procedure code for, and it will apply to the lines that we were unable to determine a rate for. It will become a default statewide CCR; it will not longer be a hospital specific CCR which is another change. If it is on the table, it will assign the rate, multiply by unit, which is 100% per unit, and apply modifier adjustments if applicable. There will be a modifier table that will reflect the adjustments. We will be adding something else that is new, and this is a peer group multiplier. We are defining certain peer groups. There will be a multiplier on our side on the PR050 – Rate Schedules table, and that multiplier will take the amount and multiply by whatever it has been determined to be for these peer groups. Currently we are looking at rural, public, and critical access hospitals as peer groups so they will have multipliers. Those that have a specific rate determine and those that have CCR, which is added up, and apply any penalty/discount and that will be the total. That is the basic process.

Sara Harper – Just a few details. The actual fee schedule is about 6000 procedure codes. They would each have a rate. The intent that 90-95% of the services on the bill are going to fall into that fee schedule category, and the 5-10% are going to default off the charge to rate ratio. As far as the bundling goes, the decision that we have not made yet is whether they will be procedure code driven or revenue code/procedure code combination. That has yet to be defined. We are leaning towards the revenue code combination.

Cia Fruitman – It will be table driven so that once the table is there then that table can be adapted by whoever needs to use it. It won't have to be hard coded. If it needs to be updated, again we will be able to drive it from the table. We are trying to keep this all table driven so that as changes come through there is no program needed, it will just be table maintenance.

Sara Harper – As far bundled services, we do have a list of revenue codes that are automatically bundled into the emergency room and surgery type services. We are looking out for the exceptions. There are about 20-30 revenue codes that will not have a procedure code with them. The hospitals have had some questions about certain things that if they are rolled into the rate they feel like their costs will not be covered. We are trying to get some examples of those from them to specifically define the parameters around how we bundle.

Q: You mentioned there were going to be unit limits. Say an outpatient bill that has several days in there, we are going to have to capture each day?
A: Lori Petre - It will be done as a range at the line level. Design will have to look at it.

Q: All the hospitals are no longer paid at cost to charge ratio, transplants any kind of hospitalization is going to be handled like this?

A: Just outpatient hospital. Outpatient services associated with a transplant will still be under your contract for transplant. That is totally different.

Q: Do you for see AHCCCS mandating us to submit encounters for the UB on the line level?
A: You all ready have to do the codes at the line level. That has been in effect since February 2002. We have not the dates on the line level yet.

Lori Petre – We have not talked about date of service at the line level with Brent at all. One way to do it is let the system push it down to the line level, and you only have to report it there if it is an exception. It is more than an exception for processing than a standard.

Q: How soon will we get those rates or even a draft of those rates?
A: Actually, the top 100 procedure rates have all ready gone out to the contractors about a month ago.

Sara Harper – We will try to email you information as it becomes available. At our next meeting in May, we should have final requirements to share with you. I am not sure what the length of time will be initially on these meetings. We play it by ear. I imagine that, as this progresses there will be more questions, issues and topics to discuss.

Meeting adjourned.